

Kansas Medical Assistance Programs



Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

P.O. Box 3571, Topeka KS 66601-3571
Prior Authorization: 1-800-285-4978 or 785-274-5499
Prior Authorization Fax Lines: 1-800-913-2229 or 785-274-5956

ADULT GROWTH HORMONE THERAPY REQUEST FORM

Consumer Name: _____ Date: ____/____/____

Consumer ID#: _____ Date Of Birth: ____/____/____

Drug Requested: _____ NDC: _____

Pharmacy Name: _____ Provider Medicaid ID#: _____

Phone Number: (____) _____ Fax Number: (____) _____

Endocrinologist Name: _____ Provider Medicaid ID#: _____

Phone Number: (____) _____ Fax Number: (____) _____

Provider Contact Person: _____ Phone Number: (____) _____

1. Please provide medical documentation from endocrinologist.

2. Diagnosis for growth hormone therapy _____

3. Results of two provocative stimulation studies, (Secretagogue testing, should confirm peak growth hormone concentration of <5ng/ml).

Date ____/____/____

_____ Insulin _____ ng/ml Normal Range _____

_____ L-Dopa _____ ng/ml Normal Range _____

_____ GERE/Arginine _____ ng/ml Normal Range _____

4. IGF-1 or IGFBP-3 value _____ Normal Range _____ Date ____/____/____

5. Provide MRI if indicated.

Signature of Physician or Designee: _____

Completed form should be faxed to 1-800-913-2229.

This form will be returned unprocessed if it is not completed in its entirety.

Initial prior authorization is for 6 months or at SRS Program Manager's discretion.